DECEPTION IN THERAPY: FORENSIC THERAPISTS' BELIEFS AND ATTITUDES

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DEDICATION

God for all His blessings

To my amazing and supportive family: Howard, Kay, Eloise, Hudson, and Uncle Franklin.

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ABSTRACT

People see deception every day by means of politics, the media, advertising, and daily interactions. One study suggests that people tell, on average, two lies a day (DePaulo & Colleagues, 1996) and "most people are often successful with their deceit" (Curtis, 2013, p.1). Therapists in a forensic setting offer a unique perspective on attitudes, perceptions, and beliefs of deception because of the clientele they work with. Criminals operate in a culture that is generally much more deceptive than non-criminals (Vrij & Semin, 1996). The purpose of this study was to determine if forensic therapists hold accurate beliefs about indicators of deception as well as explore attitudes held toward deception. Results for this study showed forensic therapists hold inaccurate beliefs about deception as well as negative attitudes toward clients who lie. These inaccuracies could cause a therapist to misinterpret behaviors as an indication of deception when a statement may in fact be the truth. These inaccurate beliefs can be detrimental to the therapeutic process due to forensic therapists indicating they hold negative attitudes toward those who lie.

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INTRODUCTION

People see deception every day by means of politics, the media, advertising, and daily interactions. One study suggests that people tell, on average, two lies a day (DePaulo, Kashy, Kirkendol, Wyer, & Epstein, 1996) and "most people are often successful with their deceit" (Curtis, 2013, p.1). People are presented with numerous opportunities each day that allow for either a deceptive interaction or a truthful one. The choice to lie can be motivated by numerous factors. People do not initially think that they are being deceived when interacting with others and therefore are prone to think that people tell the truth. As a result of this they tend to believe most of what they hear (DePaulo, 1994). However, when a person discovers they have been lied to it can irreversibly damage the relationship. An experiment showed that trust damaged by deception never fully recovers by the deceived individual (Schweitzer, Hershey, Bradlow, 2004).

WHAT IS DECEPTION

Deception can be defined as "a successful or unsuccessful deliberate attempt, without forewarning, to create in another a belief which the communicator considers to be untrue" (Vrij, 2008, p.15). One study shows that people learn to be deceptive as early as 2 years old (Sodian, Taylor, Harris, & Pemer, 1991). Jean Piaget states "the tendency to tell lies is a natural tendency…spontaneous and universal" (Wertheim, p. 64, 2016). People can communicate deception in many different ways including nonverbal cues, verbal cues, and paraverbal cues (Hart, Fillmore, & Griffith, 2010).

There are a variety of forms a lie can take: outright lies, exaggerations, and subtle lies (DePaulo et al., 1996; Vrij, 2000), as well as various motivations for why someone lies. Some motivations include: an act of self-preservation, spare embarrassment, avoid punishment, or to conceal a transgression (Vrij, 2000). However, DePaulo boiled it down to three main motivations people have for telling lies: self-oriented lies, other-oriented lies, and a combination of both (DePaulo et al., 1996). Self-oriented lies are told to protect or aid the motives of the deceiver, or told for personal gain; while other-oriented lies are told to protect or aid others (DePaulo et al., 1996). DePaulo and colleagues discovered that liars lie about themselves a great deal, utilizing self-oriented lies 50% of the time and other-oriented lies 25% of the time, with the reaming 25% using both self-oriented and other-oriented lies (DePaulo et al., 1996).

Detection of Deception

Detection of deception is of particular interest and importance for individuals in the legal, justice, and medical communities (Ellenberg, 2009). Psychologists are among the

fields of practice where deception detection can play a pivotal role in the therapeutic process allowing therapists to discuss the deceit (Curtis, 2013) if accurately detected. However, the damage caused by deception can be problematic in fields of practice should the practitioner hold negative attitudes toward deception and those who are deceptive. Forensic therapists work with clientele currently within the criminal and civil justice system. They utilize their understanding of human behavior to better interpret the explanation, prediction, and behaviors of individuals involved in the system (McClure, 2017).

Studies have shown that people are very poor lie detectors (Bond & DePaulo, 2006, Ekman, 1996; Ekman, O'Sullivan, & Frank, 1999; Vrij, 2000, 2004, 2008; Porter & ten Brinke, 2010). Almost all studies on the accuracy of deception detection have shown that accuracy is close to chance (Ekman & O'Sullivan, 1991; Bogaard, Meijer, Vrij, & Merckelbach, 2016). Society and our culture have led us to believe that people can rely on certain cues that others may exhibit when telling a lie. However, studies reveal that most people, across many different careers, hold inaccurate beliefs as to which cues may reveal a deceptive remark (Bogaard, Meijer, Vrij, & Merckelbach, 2016; Ekman, 1996; Curtis, 2013). One reason for this is people can display various behavioral cues or potentially none at all and therefore there is no consistent lying behavior (Curtis, 2013), or Pinocchio's nose (Vrij, 2000). In other words, people's noses do not grow when they are lying. Although there are not any universal behaviors, Vrij and colleagues developed a list of indicators containing verbal, paraverbal, and nonverbal behaviors that may allude to a person trying to be deceptive (1996). Hart and colleagues further refined this list to reflect 28 indicators of deception (2006; 2010). When asked to evaluate 28 indicators of deception by assigning an

increase, no change, or decrease value, therapists accurately identified four out of 28 indicators (Curtis, 2013). This gives support to other findings that people put an emphasis on behavior changes and believe them to be congruent with deception (Curtis, 2013; Hart, Fillmore, & Griffith, 2010).

Nonverbal, Verbal, and Paraverbal Behaviors

People typically look to behavioral cues to try and detect when someone is deceiving them (Hart, Hudson, Fillmore, & Griffith, 2006). Some common nonverbal indicators people look for are movements made by the deceiver with their body or facial expressions. One reason people may resort to using nonverbal cues is they assume people who practice deception are nervous and therefore reflect this nervousness with an increase in body movement (Vrij & Semin, 1996). However, research shows that there's no change in many nonverbal cues (Table 1) and a decrease in some cues such as hand and finger movements, leg and foot movements, and arm movements (Curtis, 2013). Most people when asked to describe what they look for as an indicator of deception describe hearsay or cultural wisdom (Granhag & Strömwall, 2004).

Table 1

Nonverbal Indicators of Deception

Variable	Prior Research
Eye Contact	No change
Eye Blinks	No change
Head Movements	No change
Hand and finger movements	Decrease
Arm movements	Decrease
Leg and foot movements	Decrease
Smiles	No change
Postural shifts	No change
Shrugs	No change
Gestures	No change

Adapted from Hart, Hudson, Fillmore, & Griffith, 2006

Although nonverbal indicators are important cues if accurately spotted, some studies are showing that good lie detectors rely more on verbal cues rather than nonverbal cues (Bogaard, Meijer, Vrij, & Merckelbach, 2016). Research shows that looking at the verbal content can increase diagnostic accuracy (Bogaard, Meijer, Vrij, & Merckelbach, 2016). The reason verbal cues and content may be a better indicator of deception is due to the cognitive processes that occur when disclosing a truthful statement opposed to a deceitful one. Verbal cues are also better indicators of deception due to the lack of change in nonverbal behaviors. When telling a truthful story you are recalling a memory which contains more "sensory, contextual, and affective information" than a fabricated story which is usually vaguer and less concrete (Bogaard, Meijer, Vrij, & Merckelbach, p. 2, 2016).

Verbal indicators (Table 2) include short simple sentences, a decrease in logical consistency, and more negative statements (Vrij, 2000). Opposed to nonverbal cues, verbal cues are the way we say what we say and how we articulate it. One study showed that

students and police officers relied heavily on story contradictions and the amount of details the person offered (Bogaard, et al., 2016).

Table 2

Verbal Indicators of Deception

Variable	**Prior Research**
Answer length	No change
Short simple sentences	Increase
Plausible descriptions	Decrease
Logical consistency	Decrease
Detailed description	Decrease
Unusual detail	No change
Unnecessary detail	No change
Description of feelings	No change
Describe what someone had said	Decrease
Describe interaction with others	No change
Spontaneous corrections	Decrease
Claim lack of memory	Decrease
Story contradictions	No change

Adapted from Hart, Fillmore, & Griffith, 2010

The last category is paraverbal indicators (Table 3) such as repetitions, vocal pitch, and speech errors (Akehurst, Kohnken, & Vrij, 1996; Hart, Fillmore, & Griffith, 2010) that were found to be indicators of deception (Hart et al., 2010; Sporer & Schwandt, 2006). One study shows therapists hold a firm belief stating six of six paraverbal indicators increase (Curtis, 2013) when someone is lying. Prior research suggests only 2 of 6 increased while the rest do not change (Akehurst et al., 1996; Hart et al., 2010; Vrij, 2008).

Table 3

Paraverbal Indicators of Deception

Variable	Prior Research
Number of speech interruptions	No change
Number of pauses or hesitations	No change
Latency to respond	Increase
Hectic speech pattern	No change
Pitch of voice	Increase
Length of answers	No change

Adapted from Hart, Fillmore, & Griffith, 2010

Attitudes Toward Deception

Most people would agree they don't appreciate being lied to or feeling as if they have been duped. These negative attitudes typically heighten or increase depending on the relationship the individuals previously established. Due to people's perception of lies often being considered morally wrong, people generally hold negative attitudes toward others who lie (Curtis & Hart, 2015). These negative attitudes can permeate through the relationship and have negative consequences for the future of the relationship.

Kottler and Carlson (2011) discovered that like most people therapists dislike being on the receiving end of deceit. The therapeutic relationship is crucial to the success of the client. This relationship is based on trust (Comstock, 2016). Should the therapist decide this trust has been violated or broken in any way and choose to internalize the deception, the therapeutic relationship becomes compromised. Similarly, should the client believe they have been lied to by the therapist, the negative attitudes may hinder a productive therapeutic environment. Curtis (2013) explored the attitudes of therapists' upon discovering a client had

lied to them. He explored specific attitudes (Table 4) and global attitudes (Table 5) toward deception.

Table 4

Therapists' Attitudes in Discovering a Client's Lie (Specific Attitudes Scale)

#	Attitude Item	Attitude Change
1	Liking the client*	Decrease
2	Being angry at the client	No change
3	Client as a bad person	No change
4	Thinking negatively of the client*	Increase
5	Judging the client harshly	No Change
6	Desire to interact with client*	Decrease
7	Enthusiasm to work with client*	Decrease
8	Judging client as a good client*	Decrease
9	Speaking poorly of client	No Change
10	Trusting the client*	Decrease
11	Thinking positively about client*	Decrease
12	Viewing client as sincere*	Decrease

Adapted from Curtis, 2013

The specific attitudes scale (Table 4) consisted of 12-items exploring the therapists attitudes toward a client they had discovered lied to them. Curtis (2013) discovered a statistically significant difference among 8 of the 12 attitudes indicating a negative attitude held by the therapist upon discovering a client had lied to them.

The global attitude scale (Table 5) consisted of 12-items exploring the perceptions therapists had about clients who lie in general. Curtis (2013) discovered that therapists held more negative attitudes towards clients who lie to them compared to clients who lie in general. A statistically significant difference was found among 5 of the 12 items, all 5 were negative attitudes toward clients who lie in therapy (Curtis, 2013).

Table 5

Therapists' Attitudes Toward Clients who Lie in Therapy (Global Attitudes Scale)

#	Attitude Item	Attitude Change
13	Successful*	Decrease
14	Pathological	No change
15	Weak	No change
16	Compliant*	Decrease
17	Predictable	No change
18	Pleasant*	Decrease
19	Lazy	No change
20	Awkward	No change
21	Knowledgeable	No change
22	Intelligent	No change
23	Likable*	Decrease
24	Adjusted*	Decrease

Adapted from Curtis, 2013

THERAPY

Therapy is something many have struggled to define. It can mean many different things to different people especially when you attempt to define it in a manner representative of different cultural practices. Many who have attempted to define therapy do so in terms related to theories, experiences, and philosophies (Curtis, 2013). Corsini and Wedding (2007) define psychotherapy as:

> "…a formal process of interaction between two parties, each party usually consisting of one person but with the possibility that there may be two or more people in each party, for the purpose of amelioration of distress in one of the two parties relative to any or all of the following areas of disability or malfunction: cognitive functions (disorders of thinking), affective functions (suffering or emotional discomforts), or behavioral functions (inadequacy of behavior). The therapist who takes part in this interaction has some theory of personality's origins, development, maintenance, and change, applies some method of treatment logically related to the theory, and has professional and legal approval to act as a therapist." (p. 1)

Corsini and Wedding made special note that some modes of therapy will not fit this definition (2007). However, this definition is strong because it describes the nature of therapy and the purpose of therapy as it relates to relieving the client's distress (Curtis, 2013).

Deception in Therapy

Psychology is defined as the study of the mind and behavior (Aanstoos, 2016). Although most therapists do not receive formal training in deception detection they do

receive training in human behavior and how to become astutely aware of discrepancies in behavior (Curtis, 2013). Although therapists have studied psychology and have training in noticing discrepancies in behavior, Curtis (2013) found that therapists do not hold accurate beliefs when it comes to detecting deception. Should a therapist determine they have been duped they may have a negative reaction toward the client, in fact, many therapists after discovering they had been deceived by a client reported initial feelings such as anger, shame, and embarrassment (Curtis, 2013). Rather than internalizing the client's deceit it may prove more beneficial for therapists to explore the client's reasoning for the deception. Kottler & Carlson (2011) noted that a therapists job is to attempt to understand why a client was deceptive and interpret what the deception means to the client therapist relationship as well as for the therapy (p. 225).

FORENSIC THERAPISTS

There is a huge role within corrections for psychologists however they have been underutilized due to budget constraints and lack of understanding of the value they can bring. Psychologists are not only useful for counseling inmates but they can also provide their services by training and counseling staff, evaluating programs, as well as play a pivotal role in policy making with their background in human behavior (Hawk, 1997). Current roles for psychologists within corrections is finding ways to implement therapy while being mindful of security requirements and keeping alert (Varghese, Magaletta, Fitzgerald, & McLearen, 2015) this also includes attempting to determine the well-being of inmates regarding placement into programs and special housing. Inmates may choose to manipulate the process in an effort to be placed where they want, which can potentially have negative consequences when it comes to the safety of the individuals working and serving time at the facility. Correctional facilities and the individuals serving their time operate by a very different set of rules then those who maintain the right to their freedom. Individuals within correctional facilities tend to find ways to resolve matters they deem need handling, amongst themselves and more often than not using violence. According to Page (2000), "violence is a dominant and defining thread running through the fabric of jail and prison life (p. 134). Unfortunately many of these assaults are overlooked or not reported out of fear one might be labeled a "snitch" (Robertson, 2007). Individuals who choose to provide therapy to inmates must address and accept their feelings about possible crimes, behaviors, and personalities they will encounter when handling the inmate population in order to assist the individual in changing their criminal behaviors and way of thinking (Varghese, et al., 2015). Correctional therapists

must be able to work with individuals from many diverse backgrounds and be able to develop treatment plans while the inmate is in prison as well as begin developing tools with the inmate to use and be successful once they leave the facility and return to society. Another crucial role psychologist's play within prison settings is to help inmates cope with the effects of short and long term incarceration (Hawk, 1997). The goal with this is to provide inmates with the coping skills necessary for incarceration and how to respond constructively to the effects of incarceration on the individual and their family in hopes of helping maintain a safe and healthy environment for inmates and staff (Hawk, 1997).

Reducing Recidivism

By the end of 2015 over 6.7 million individuals were supervised by the adult correctional system in the United States (Kaeble & Glaze, 2016). Most of these individuals will be released back into the community in which they initially offended (McMahon, 2015). Studies reveal roughly two-thirds of these individuals will reoffend within three years of being released from prison (McMahon, 2015) suggesting the criminal mindset is crystalized and difficult to change to be more prosocial. Many of these individuals reoffend because their way of life that originally put them in the system is the only way of life they know (McMahon, 2015). Criminologists agree that the only way to reduce recidivism rates is to implement and make accessible correction programs and rehabilitation services for offenders before they are to be released from their sentence (Meehan, 2015). Some programs that have been shown to be effective in reducing recidivism are: general and specific cognitive-behavioral programs, vocational education, and drug treatment (McMahon, 2015). For these programs to work it requires the individual to be honest about their thoughts, behaviors, and

emotions in order to work through the criminal mindset and adapt criminal thinking to more pro-social thinking. Although these reductions in recidivism may be small it appears to have a much larger impact on society (McMahon, 2015).

DECEPTION WITHIN A FORENSIC CONTEXT

Feigning symptoms of psychiatric disorders or malingering has become more popular amongst offenders in an attempt to aid in their case, receive medication, or fulfill another agenda such as placement within a jail medical facility. All of this is believed to be an attempt to evade responsibility for their legal charges (Saberi, Sheikhazadi, Ghorbani, Nasrabadi, Meysamie, & Marashi, 2013). Malingering is the "intentional use of deception for an external motivation" (Saberi, et al., 2013). It is important for psychologists when dealing with individuals who are part of the criminal justice system to be able to determine genuine from feigned symptoms (Saberi, et al., 2013). On the other side of the coin some offenders attempt to dissimulate pre-existing illnesses and disorders from forensic evaluators (Martino, et al., 2016). Dissimulation is the act of concealing or hiding an illness in an effort to advantage an ulterior motive (Martino, et al., 2016). Motivations for these individuals may include employment acquisition, insurance purposes in which the disorder requires a higher premium, and certifications such as permission for a firearm or a driver's license (Martino, et al., 2016). Within a jail setting, depending on the disorder, dissimulation of a psychiatric disorder is difficult to conceal for a long period of time. The individual is usually discovered as a faker (Martino, et al., 2016) however this may at times be at the expensive of the safety of other inmates, guards, or the individual. Due to inmates feigning symptoms or dissimulating a preexisting condition it is imperative for jail psychologists to have resources to aid in detecting possible psychopathology.

Deception Assessment within a Forensic Context

There are multiple assessments available to assist jail officials when assessing an inmate. The Structural Interview of Reported Symptoms (SIRS) is a popular assessment used to screen and appraise feigned and exaggerated symptoms (Walters, 2011). Like most assessments it takes time for the individual to complete the assessment. When it comes to any service provided to inmates, the state must be able to justify the cost. Lengthy assessments are not cost effective for most facilities. In an effort to address this issue, shorter self-report interviews, assessments, and multiscale inventories have been devised such as: the Miller-Forensic Assessment of Symptoms Test (M-FAST), Minnesota Multiphasic Personality Inventory (MMPI-2), and the Personality Assessment Inventory (Walters, 2011). The MMPI-2 utilizes a deception detection strategy by inserting items to assess the validity of a measure (Curtis, 2013). These items evaluate the client responding in a manner that is intentionally misleading to the assessor (Curtis, 2013). The PAI utilizes three measures like the Negative Impression scale (NIM) to detect symptoms of psychopathology that have been over reported (Hawes & Boccaccini, 2009). The other two scales used in the PAI, The Malingering Index (MAL) and The Rogers Discriminant Function (RDF), were developed to identify profile characteristics suggestive of malingering (Hawes & Boccaccini, 2009). These profile characteristics remain consistent amongst those who have a genuine mental disorder (Hawes & Boccaccini, 2009).

Studies of worldwide incarcerated individuals have shown how prevalent mental disorders are behind bars and their role in crimes as well as recidivism. Antisocial personality disorder (ASPD) has been determined to affect about 47% of male prisoners worldwide

(Jiang, Liu, Ma, Rong, Tang, & Wang, 2013). According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) antisocial personality disorder includes symptoms such as disregard for others rights, lack of remorse, and aggressiveness (American Psychiatric Association, 2013, p.659). Along with these symptoms the DSM-5 reports deceitfulness as a symptom of ASPD (American Psychiatric Association, 2013, p.659). Although assessments may be used as a tool to inform possible psychopathologies it does not assist the therapist in accurately detecting deception during a session or intake with the individual.

Nearly 74% of inmates struggle with a clinical diagnosis of alcohol or substance disorder (Richards & Pai, 2003). More jails and prisons have implemented treatment programs within their facilities to promote better prison management, assist in lowering rates of transgressions while in prison, and reduce the use of illicit drugs behind bars (Richards & Pai, 2003). In order for inmates to be admitted into the jail treatment program the individual must go through an intake process. The intake process evaluates inmates on drug use and its relation to criminal conduct and identifying motivation for change (Richards & Pai, 2003). The intake processes relies mostly on self-report of the inmates history with substance abuse. Prisons are permitted to request a urinalysis or a hair follicle sample to be tested against a drug panel; however the urinalysis requires the test to be conducted within a limited time of having used drugs, while the hair follicle can turn up inconclusive. This results in jail officials and psychiatrists using self-report scales to determine substance abuse and its extent. Scales such as the Substance Abuse Subtle Screening Inventory (SASSI) and the Drug Abuse Screening Test (DAST) have not been successful in addressing possible deception (Richards

& Pai, 2013). More comprehensive personality and psychopathology tests such as the MMPI have designed scales to detect individuals over or under reporting symptoms (Marion, et al., 2013). In addition to these assessments cost for the instrument and for a professional's time to interpret results another limitation is they have also been shown to be vulnerable to deception on the substance abuse scale (Richards & Pai, 2013). Some prisons offer a Residential Drug Abuse Program (RDAP) which requires 500 treatment hours and inmates are permitted to live in a residential setting (Raney, Magaletta, & Hubbert, 2005). The incentive of the living arrangements as well as possibility of time taken off the inmates' sentence for completion of the program tends to draw a large number of applicants for the program. Those selected for the program were subjected to a rigorous screening and assessment process (Raney, et al., 2005) in which interviewers must be able to accurately detect those who are dedicated to the program and those attempting to deceive the interviewer in an effort to receive the incentives of the program.

PURPOSE OF THE STUDY

One study conducted by Curtis (2013) looked at therapist's beliefs and attitudes about deception. Curtis did this by asking participants to indicate their beliefs about deception cues using a closed-question method based off of prior research results of nonverbal, paraverbal, and verbal indicators (2013). Within Curtis' dissertation he noted the expanding interest in deception and expressed a need to expand research on deception within a forensic setting (Curtis, 2013). Therapists in a forensic setting offer a unique perspective on attitudes, perceptions, and beliefs of deception because of the clientele they work with. Criminals operate in a culture that is generally much more deceptive than non-criminals (Vrij & Semin, 1996). This may be a reason for forensic settings placing an emphasis on deception detection and may cause forensic therapists to be more motivated to detect deception with their clients (Curtis, 2013).

The proposed research looked at bridging the gap of several fields that have already been investigated individually: counseling psychology, clinical psychology and forensic areas (Curtis 2013; Ekman, O'Sullivan, Frank, 1999; Granhag & Stromwall, 2004). Approximately 11.4 million people were incarcerated in 2014, most of these individuals were in need of behavioral health interventions like substance abuse rehabilitation and mental health treatment (Moore, et al., 2016). Forensic psychologists are interested in "assessment, consultation, psychotherapy, and the study of human behavior and thinking within judicial systems" (McClure, 2015, p.1). Forensic psychologists are dedicated to understanding human behavior as well as understanding and changing criminal thinking that lead to criminal behaviors. One area of forensic psychology pertains to court appointed drug rehabilitation

centers. The number of substance abuse offenders being referred to treatment facilities is increasing (Gallagher, 2014). For those who are not court ordered to a rehabilitation program or do not need substance rehabilitation, counseling services are available for them at the prison. Jail is an environment where security is crucial and rehabilitation is the goal, therefore it is a place where deception detection is crucial and holding inaccurate beliefs may have severe consequences (Curtis, 2013).

Consequently, counselors in these settings may hold negative attitudes toward individuals who lie to them. This can affect numerous things conducive to a productive therapy session like the therapeutic alliance, relationship, and the outcome (Curtis, 2013). One study performed by Curtis revealed therapists "hold negative attitudes toward clients who lie" (Curtis, 2013, p. 104). These attitudes included thinking more negatively about a client whom they discovered was deceptive to them, feeling less enthused to work with that client, as well as a decreased desire to interact with that client (Curtis 2013). Curtis (2013) also discovered therapists hold negative global attitudes toward clients who lie in therapy. Therapists indicated they view clients who lie as less successful, less pleasant, and less compliant (Curtis, 2013). These attitudes may pose problematic obstacles between the client and the therapist, and are therefore not beneficial to a successful therapeutic relationship. Due to prior research showing therapists hold some negative attitudes toward clients who lie it was imperative to look at the beliefs therapists hold about indicators of deception. Curtis' findings (2013) indicated therapists held correct beliefs about only 6 out of 28 indicators of deception. These inaccurate beliefs may lead to a therapist determining a client is lying, the therapist may then internalize the deception and consequently hold negative attitudes toward

the client. The ability to accurately detect deception allows the therapist to discuss the deception attempt with the client allowing a deeper look into the nature of the lie (Curtis, 2013) and potentially some insight into criminal behavior. Rather than internalizing the deception it may be more beneficial for the client and therapist to explore the motivation of the lie.

METHODS

Participants

The current study contacted and recruited professionals who work with clients in a forensic setting. Correctional rehabilitation programs provide professional, cost effective alternatives to incarceration. These professionals provide programming for offenders with substance and alcohol abuse, emotional problems, and mental health problems. This study also recruited professionals who work within prisons and provide counseling to inmates as well as therapists who see clients that are mandated by the court for counseling or assessment.

The sample size was calculated using G*Power (Faul, Erdfelder, Buchner, & Lang, 2009). For computing a priori sample size with an effect size of .5 and an alpha of .05 the sample size needed was 45. For a repeated measures ANOVA with an effect size f of .25, alpha .05, and 3 measurements the sample size needed was 43.

The current study recruited 48 participants 10 of whom did not complete the survey after the demographics questionnaire and were excluded from analysis. Eligibility requirements for participants included: (a) at least 18 years old, (b) completed at least one practicum course working with clientele in a forensic setting, and (c) currently in or have completed training in a counseling or clinical psychology program.

Demographics

Participants were recruited using a listserv contacting the American Psychological Association Division 18 and program directors who work within the forensic field and asking them to help disseminate the study to their contacts and colleagues fitting the criteria

expressed above. Participants were also recruited through personal research of forensic therapists, the use of state Psychological Association websites, and forensic therapists contact information provided by other professionals. The participants ranged in age from 25-67 years old (M = 45.9, SD = 14.82). Majority of participants identified as woman.

The majority of participants were Caucasian/European American (86.8%) with others identifying as African American/Black (2.6%), Hispanic/Latino/Latina (5.3%), and Bi Racial (5.3%). Participants were asked to report their highest degree earned. Most of the participants indicated a Master's degree (36.8%) as their highest degree earned. Other degrees reported by participants were Ph.D. (23.7%), 4 year college degree (15.8%), while the remaining reported "Other" specifying Associate degrees as well as Doctor of Psychology degrees or Psy.D..

Participants were asked to report their training program and license they hold (Table 6). Ten participants identified "Other" regarding licensure specifying Licensed Professional Counselor Supervisor, currently no license, and individuals actively working towards a LPC.

Table 6

License Held

License	***n***	**Percentage**
Licensed Chemical Dependency Counselor	6	15.8%
Licensed Chemical Dependency Counselor-Intern	4	10.5%
Licensed Professional Counselor	4	10.5%
Licensed Professional Counselor-Intern	4	10.5%
Licensed Psychological Associate	1	2.6%
Licensed Psychologist	8	21.1%
Other	10	26.3%

Note: Frequencies not adding to 38 and percentages not adding to 100% reflect missing data

Participants were asked to disclose their current therapy work setting. A majority of the participants identified "Other" work settings not included on the questionnaire such as: maximum correctional facilities, private practice, probation, detention centers, inpatient and outpatient care, Veterans Affairs programs, juvenile corrections, academia, jail facilities, Mental Health and Intellectual and Developmental Disability Authority (MHMR), and Community Mental Health Centers (CMHC). Other participants indicated their work setting as a Men's Community Correctional Facility - CRTC (15.8%) and a Women's Community Correctional Facility – CRTC/SAAFPF (15.8%).

Participants were asked to report their years of counseling experience, time ranged from 5 months to 41 years. In asking participants to approximate the amount of direct contact hours they have accrued, majority of participants disclosed a weekly approximation while others did not report. Missing data may be due to having participants attempt to recall an approximate number of direct contact hours from their counseling experience.

Table 7 displays participants' training and experience with deception. The variables were measured on a 7 point Likert-type rating scale (1 = none, 7 = very much). Most participants disclosed they have not had a considerable amount of training in deception or deception detection.

Table 7

Therapist Training and Experience with Deception

Training Variable	***n***	**Mean (SD)**
Amount of literature read on deception	38	3.26 (2.088)
Training with deception	38	2.92 (1.761)
Training with deception detection	38	2.61 (1.733)

Measures and Materials

The current study used four measures: Demographics Questionnaire, Detection of Deception Questionnaire, Therapists' Attitudes Toward Deception, and Beliefs about Client Deception Questionnaire.

Demographic Questionnaire: Participants were asked to complete the Demographic Questionnaire (Appendix A). The questionnaire asked participants to provide information about age, gender, race, education, license, and current work setting. It also asked about the training the individual has had on deception and detecting deception as well as how long the professional has been practicing.

Detection of Deception Questionnaire: The DDQ (Appendix B) is a questionnaire developed by Hart and colleagues (2006; 2010) and has been used to assess participant's beliefs about cues to deception (Curtis, 2013 & 2015). The DDQ consists of 30 items total. The questionnaire uses a 7 point Likert-type rating scale that asked participants to indicate various changes in behavior in response to detecting deception. It also uses a 7 point Likert-type rating scale to indicate the level of confidence in detecting deception and how often participants thought people lied to them.

Therapists' Attitudes Toward Deception Scale: The TATDS (Appendix C) was created by Curtis (Curtis, 2013). This study uses the first 24 items of the TATDS and the final item of the TATDS. The first 12 items asked participants to indicate how their attitudes would change if they discovered a client was lying in therapy using a 9 point Likert-type rating scale. The next 12 items were adapted by Curtis to assess therapists' perceptions of attributes the clients who lie in therapy possess opposed to those who do not using a 7 point

Likert-type rating scale. The final item was used by Curtis (2013) to assess how many clients the therapist believe lie using a percentage. The TATDS' internal consistency is relatively reliable showing Cronbach's alpha at .83 (Curtis, 2015).

Beliefs about Client Deception Questionnaire: The BCDQ (Appendix D), constructed for this study, consisted of 8 items and can be broken down into three parts. The first two questions are based on perceptions of deception contrasting forensic clients and non-forensic clients based on a 7-point Likert-type rating scale (1 = significantly less, 4 = no change, 7 = significantly more). The second part (questions 3-5) asked what the counselor relies on and to what degree when attempting to detect deception. This asked participants to indicate on a 7-point Likert-type rating scale (1 = less often, 4 = no change, 7 = more often). The third part (questions 6-8) is based off DePaulo's findings of motivations for lying. DePaulo discovered that 50% of lies are self-oriented, 25% are other-oriented, while the remaining 25% are a combination of the two (DePaulo et al., 1996). Questions 6-8 asked participants to indicate their perception of clients motivation to lie on a 5-point Likert-type rating scale (1 = never, 5 = always). This questionnaire looked at the counselor's perception of the client's motivation to use deception and then compared them to DePaulo's findings of self-oriented lies, other-oriented lies, and a combination of the two.

Procedures

An email (Appendix E) containing a brief summary of the study and a link was sent to each forensic therapist contact. The email indicated the purpose of the study and asked the recipient to forward the email to other therapists fitting the eligibility requirements, and provided a link to the study. After selecting the link participants were directed to an informed

consent form (Appendix F) on PsychData. Upon reading and acknowledging an understanding of the minimal potential risks participants were asked to click continue, which implied their consent to participate in the study. After the participant consented to participate in the study they were guided to the demographic questionnaire (Appendix A). Forensic therapists were then asked to complete the Detection of Deception Questionnaire (Appendix B), Therapists' Attitudes Toward Deception (Appendix C), and finally the Beliefs about Client Deception Questionnaire (Appendix D). No personal information was collected and therefore there was no identifying data attaching a person to their responses. All data was downloaded from PsychData to Statistical Package for the Social Sciences (SPSS) then analyzed.

The study intended to compare the results to Curtis' findings looking at professionals with credentials in counseling and clinical psychology (Curtis, 2013). Curtis' found non-forensic therapists displayed a statistical significance among 8 of the 12 attitude items where all 8 attitudes were negatively held (Curtis, 2013). The current study compared its findings for forensic therapist's attitudes toward deception with Curtis' findings for non-forensic therapists.

HYPOTHESES

The data gathered from PsychData was organized, coded, and analyzed using the Statistical Package for Social Science (SPSS) program. The following were research questions and hypothesis for the proposed study.

Research Questions and Hypothesis

Question 1. Do forensic therapists hold a truth bias or a lie bias?

Hypothesis 1. It was predicted that forensic therapists hold a lie bias, most clients lie most of the time. This was assessed using the second item of the DDQ and the final item of the TATDS using a frequency analysis for both items.

Question 2. What attitudes do forensic therapists have toward clients who lie?

Hypothesis 2. It was predicted that most forensic therapists would identify a negative attitude for at least 1 out of 24 attitude items and perceive the client as having socially negative attributes. This was assessed using the TATDS by running a one sample *t*-test for each of the 24 items.

Question 3. Do forensic therapists hold accurate beliefs about indicators of deception?

Hypothesis 3. It was predicted that forensic therapists, much like the general public, hold false beliefs about most indicators of deception. This was assessed using a one-sample *t*-test with a no change anchor of 4 for each of the non-verbal, paraverbal, and verbal indicators in the DDQ.

Question 4. What do forensic therapists believe the motivation is for their clientele to lie?

Hypothesis 4. It was predicted that forensic therapists' beliefs of clientele's motivations for lying leans significantly more toward self-oriented motivations rather than the distribution presented by DePaulo's findings: 50% self-oriented, 25% other-oriented, 25% combination of both. This was assessed with the BCDQ using a frequency analysis for all three items, then by using the BCDQ by means of a one-way repeated measures ANOVA for each category.

Question 5. What types of indicators do forensic therapists rely on?

Hypothesis 5. It was predicted that forensic therapists rely more on nonverbal indicators than verbal and paraverbal indicators. This was assessed using the BCDQ by means of a one-way repeated measures ANOVA to compare each indicator category.

RESULTS

The current study recruited a total of 48 participants 10 of whom did not complete the survey after the demographics questionnaire and were excluded from analysis. Thus the total number of participants included in the statistical analysis was 38. Some data was missing in a few areas of the various instruments.

Research Questions and Hypotheses

Question 1. Do forensic therapists hold a truth bias or a lie bias?

Hypothesis 1. It was predicted that forensic therapists hold a lie bias, most clients lie most of the time. A one-sample t-test was conducted on the second item of the DDQ to assess the sample mean of forensic therapists' compared to non-forensic therapists' belief of how often they think clients would be deceptive to them. Results revealed forensic therapists have a moderate belief that clients would be deceptive to them (M = 4.71, SD = 1.228) supporting the hypothesis that forensic therapists hold a lie bias. This data was compared to prior research using a non-forensic therapist population. Results indicated non-forensic therapists also hold a moderate belief that clients would be deceptive to them (M = 4.15, SD = 1.240), however this score was not statistically significant (p = .242, Cohen's d = 0.454).

A frequency analysis was used on the final item of the TATDS asking participants what percentage of clients on their caseload are liars. Results varied with most participants indicating 50% or more of their clients on their caseloads as liars. Many participants chose to not answer this question or indicated they currently did not have a caseload.

A frequency analysis was used on the second item of the DDQ asking participants how confident they are at detecting when clients are deceptive to them. Results were assessed

on a 7-point Likert scale with 1 indicating not very confident and 7 indicating very confident. Results revealed forensic therapists have moderate confidence (M = 3.95, SD = 1.251) in their ability to detect client deception.

Question 2. What attitudes do forensic therapists have toward clients who lie?

Hypothesis 2. It was predicted that most forensic therapists would identify a negative attitude for at least 1 out of 28 attitude items and perceive the client as having socially negative attributes. One sample t-tests were conducted on each of the specific attitudes related to attitudes toward discovering client deception (items 1-12 on TATDS) to determine if there was a statistically significant difference from a 5 anchor score. A Bonferroni adjustment was used in the analysis (Bonferroni correction = .004). A statistically significant difference was found among 4 of the 12 attitude items in which all 4 were negative (Table 8). The 4 negative attitudes were: (a) judging the client as a good client, (b) trusting the client, (c) thinking positively about the client, and (d) viewing the client as sincere. These results show forensic therapists as holding more than one negative attitude toward deception and therefore this hypothesis was supported.

Table 8

Forensic Therapists' Attitudes when Discovering Client Deception

Attitude Item	*n*	Mean(*SD*)	*t*	Attitude Change
Liking the client	38	4.74 (.760)	-2.135	No change
Being angry at the client[RC]	38	4.74 (.921)	-1.762	No change
Client as a bad person[RC]	38	5.05 (.769)	.422	No change
Thinking negatively of the client[RC]	38	4.79 (.741)	-1.751	No change
Judging the client harshly[RC]	38	4.82 (.563)	-2.018	No change
Desire to interact with client	37	4.81 (1.023)	-1.125	No change
Enthusiasm to work with client	38	4.66 (.938)	-2.248	No change
Judging client as a good client	38	4.61 (.679)*	-3.582	Decrease
Speaking poorly of client[RC]	38	4.76 (.943)	-1.549	No change
Trusting the client	37	3.59 (1.607)*	-5.321	Decrease
Thinking positively about client	38	4.32 (.933)*	-4.520	Decrease
Viewing client as sincere	38	3.61 (1.534)*	-5.604	Decrease

Note: *p<.004
[RC]: Indicates a Reverse Coding

One sample t-tests were also conducted on each of the items related toward global attitudes of clients who lie in therapy (items 13-24 on TATDS). This was used to determine if forensic therapists demonstrated a statistically significant difference from an anchor score of 4. A Bonferroni adjustment was used in the analysis (Bonferroni correction = .004). A statistically significant difference was found among 5 of the 12 attitude items, in which 3 were negative attitudes (Table 9). The three negative attitudes were: (a) successful, (b) compliant, and (c) adjusted. The attitudes that showed a statistically significant increase from the 4 point anchor were weak and lazy, indicating forensic therapists hold a moderate belief of clients who lie as being not very weak or lazy.

Table 9

Forensic Therapists' Attitudes Toward Clients who Lie in Therapy

Attitude Item	*n*	Mean(*SD*)	*t*	Attitude Change
Successful	38	2.95 (1.413)*	-4.592	Decrease
Pathological[RC]	37	4.32 (1.270)	1.553	No change
Weak[RC]	38	4.76 (1.422)*	3.307	Increase
Compliant	38	2.71 (1.228)*	-6.472	Decrease
Predictable	38	3.55 (1.309)	-2.107	No change
Pleasant	36	3.61 (1.225)	-1.904	No change
Lazy[RC]	38	4.66 (1.321)*	3.070	Increase
Awkward[RC]	37	4.51 (1.304)	2.395	No change
Knowledgeable	38	3.82 (1.136)	-1.000	No change
Intelligent	38	4.18 (.926)	1.227	No change
Likable	38	3.61 (1.152)	-2.113	No change
Adjusted	37	3.14 (1.417)*	-3.712	Decrease

Note: *p≤.004
[RC]: Indicates a Reverse Coding

The attitudes toward deception scales were compared for forensic therapists and non-forensic therapists. For the specific attitudes scale, forensic therapists held four negative attitudes whereas non-forensic therapists held eight negative attitudes. Comparative findings for the global attitude scale showed non-forensic therapists held five negative attitudes toward clients who lie whereas forensic therapists held three negative attitudes.

The findings for attitudes toward deception were summed into a total attitude score then compared for forensic therapists and prior research findings for non-forensic therapists. Results for forensic therapists (M = 99.77, SD = 9.471) and non-forensic therapists (M = 96.40, SD =10.045) showed no statistical difference between attitudes held toward clients who lie.

Question 3. Do forensic therapists hold accurate beliefs about indicators of deception?

Hypothesis 3. It was predicted that forensic therapists, much like the general public and non-forensic therapists, hold false beliefs about most indicators of deception. This was assessed using a one-sample *t*-test for each of the non-verbal, paraverbal, and verbal indicators in the DDQ. This was used to determine if forensic therapists demonstrated a statistically significant difference from an anchor score of 4. A Bonferroni adjustment was used in the analysis (Bonferroni correction = .002). Among the 28 indicators of deception, forensic therapists held accurate beliefs about five indicators: (a) eye blinks, (b) pitch of voice, (c) length of answers, (d) description of feelings, and (e) description of interactions (Table 10). This hypothesis was supported showing forensic therapists hold inaccurate beliefs about 23 indicators of deception.

Table 10

Forensic Therapists' Beliefs about Indicators of Deception

Variable	Mean (*SD*)	t	Belief	Prior Research
Nonverbal Indicators				
Eye Contact	3.13 (1.359)	-3.939*	Decrease	No change
Eye Blinks	4.55 (1.108)	3.076	No change	No change
Head Movements	4.76 (.943)	4.991*	Increase	No change
Hand and finger movements	4.89 (.953)	5.790*	Increase	Decrease
Arm movements	4.51 (.870)	3.591*	Increase	Decrease
Leg and foot movements	5.14 (1.032)	6.692*	Increase	Decrease
Smiles	4.58 (.967)	3.618*	Increase	No change
Postural shifts	5.05 (.880)	7.284*	Increase	No change
Shrugs	4.65 (.824)	4.789*	Increase	No change
Gestures	4.76 (.820)	5.738*	Increase	No change
Paraverbal Indicators				
Speech interruptions	4.89 (1.110)	4.969*	Increase	No change
Pauses or hesitations	4.97 (1.013)	5.840*	Increase	No change
Latency to respond	4.70 (1.331)	3.213	No change	Increase
Hectic speech pattern	4.65 (1.006)	3.922*	Increase	No change
Pitch of voice	4.82 (.865)	5.811*	Increase	Increase
Length of answers	4.66 (1.300)	3.119	No change	No change
Verbal Indicators				
Short simple sentences	4.00 (1.434)	.000	No change	Increase
Plausible descriptions	4.29 (1.450)	1.230	No change	Decrease
Logical consistency	3.26 (1.408)	-3.226	No change	Decrease
Detailed description	4.00 (1.560)	.000	No change	Decrease
Unusual detail	4.89 (1.290)	4.275*	Increase	No change
Unnecessary detail	5.24 (.971)	7.854*	Increase	No change
Description of feelings	3.74 (1.519)	-1.068	No change	No change
Describe what someone said	3.89 (1.607)	-.404	No change	Decrease
Description of interactions	4.00 (1.577)	.000	No change	No change
Spontaneous corrections	4.89 (1.350)	4.020*	Increase	Decrease
Claim lack of memory	5.45 (1.032)	8.647*	Increase	Decrease
Story contradictions	5.63 (1.051)	9.573*	Increase	No change

Note: *p<.002

Question 4. What do forensic therapists believe the motivation is for their clientele to lie?

Hypothesis 4. It was predicted that forensic therapists' beliefs of client's motivation for lying skews significantly more toward self-oriented motivations rather than the distribution presented by DePaulo's (1996) findings: 50% self-oriented, 25% other-oriented, 25% combination of both. This was assessed with the BCDQ using a frequency analysis for all three items, then by using the BCDQ by means of a one-way repeated measures ANOVA. A repeated measures ANOVA with lie orientation scores as a repeated measure variable found a significant large main effect, $F(2, 35) = 15.92$, $p < .001$, $\eta p2 = .48$. Results suggest that forensic therapists perception of whom clients lie for are: for themselves ($M = 3.76$, $SD = .641$), for others ($M = 2.89$, $SD = .809$), and for themselves and others ($M = 3.49$, $SD = .651$). Forensic therapists indicated they perceive clients lie for themselves more than for others or for themselves and others supporting this hypothesis.

Question 5. What types of indicators do forensic therapists rely on?

Hypothesis 5. It was predicted that forensic therapists rely more on nonverbal indicators than verbal and paraverbal indicators. This was assessed using the BCDQ by means of a one-way repeated measures ANOVA. A repeated measures ANOVA with indicator scores as a repeated measure variable revealed no statistically significant difference, $F(2, 35) = .37$, $p = .67$, $\eta p2 = .02$. Results revealed no statistical significance between the three variables. Forensic therapists reported a higher mean score for paraverbal cues ($M = 4.89$, $SD = 1.286$) than nonverbal cues ($M = 4.76$, $SD = 1.090$) and verbal cues ($M = 4.73$, $SD = 1.146$). Due to no statistical significant difference this hypothesis was not supported.

Comparative Data Results

The beliefs about indicators of deception findings were compared for forensic therapists and prior research findings for non-forensic therapists. Results showed forensic therapists hold five correct beliefs about deception whereas non-forensic therapists held six correct beliefs out of the 28 indicators (Table 11).

Table 11

Forensic Therapists' Compared to Non-Forensic Therapists Beliefs about Indicators of Deception

Variable	Forensic Belief	Non-Forensic Belief	Compared Belief
Nonverbal Indicators			
Eye Contact	Decrease	Decrease	Similar
Eye Blinks	No change[C]	Increase	Different
Head Movements	Increase	No change[C]	Different
Hand and finger movements	Increase	Increase	Similar
Arm movements	Increase	No change	Different
Leg and foot movements	Increase	Increase	Similar
Smiles	Increase	No change[C]	Different
Postural shifts	Increase	Increase	Similar
Shrugs	Increase	Increase	Similar
Gestures	Increase	Increase	Similar
Paraverbal Indicators			
Speech interruptions	Increase	Increase	Similar
Pauses or hesitations	Increase	Increase	Similar
Latency to respond	No change	Increase[C]	Different
Hectic speech pattern	Increase	Increase	Similar
Pitch of voice	Increase[C]	Increase[C]	Similar
Length of answers	No change[C]	Increase	Different
Verbal Indicators			
Short simple sentences	No change	Decrease	Different
Plausible descriptions	No change	No change	Similar
Logical consistency	No change	Decrease[C]	Different
Detailed description	No change	No change	Similar
Unusual detail	Increase	Increase	Similar
Unnecessary detail	Increase	Increase	Similar
Description of feelings	No change[C]	Decrease	Different
Describe what someone said	No change	No change	Similar
Description of interactions	No change[C]	No change[C]	Similar
Spontaneous corrections	Increase	No change	Different
Claim lack of memory	Increase	Increase	Similar
Story contradictions	Increase	Increase	Similar

Note: [C] Correct belief according to prior research (Hart, Hudson, Fillmore, & Griffith, 2006)

DISCUSSION

The present study explored forensic therapists' beliefs and attitudes toward deception. The finding that forensic therapists hold many inaccurate beliefs about indicators of deception is congruent with prior research findings involving non-forensic therapists (Curtis, 2013). These research results were also congruent among populations including undergraduate university students, managers, police officers, and teachers (Colwell, Miller, Miller, & Lyons, 2006; Forrest, Feldman, & Tyler, 2004; Hart et al. 2006, 2010; Reinhard, Dickhäuser, Marksteiner, & Sporer, 2011). The forensic therapists' who participated held only five correct beliefs about indicators of deception out of 28 listed while non-forensic therapists held six correct beliefs.

According to the Global Deception Research Team (2006) gaze aversion is the most common belief about deception and this is a belief that is held worldwide. Both populations, forensic and non-forensic therapists, held similar beliefs indicating a decrease in eye contact as being an indicator of deception. Forensic therapists also held other common incorrect beliefs indicating increase in body movements, changes in speech interruptions, tone of voice, and indicating an increase in weak, illogical arguments (Global Research Team, 2006).

This study also explored how often forensic therapists rely on verbal, paraverbal, and non-verbal indicators of deception. Results did not show a statistical significance for indicators forensic therapists rely on indicating no difference found. These findings are incongruent with what is suggested by research as good indicators to rely on more so than other indicators. Prior research has shown that good lie detectors rely more on verbal indicators (Bogaard, et al., 2016) because this is where we see the most fluctuation among

indicators of deception. Counter intuitively, non-verbal indicators are where we see the least change in behavior. Consequently non-verbal behaviors are one of the areas where forensic therapists consistently indicated they felt they would see an increase, indicating eight out of ten indicators increase when someone is being deceptive.

The implications of these incorrect beliefs may permeate into the client therapist relationship due to negative attitudes held about those who are deceptive. Due to the stigmas that surround the offender population and how the public perceives these individuals it was predicted that forensic therapists would hold negative attitudes towards those who are deceptive. These research findings were congruent with findings of non-forensic therapists in that forensic therapists also held negative attitudes toward clients who lie. Due to forensic therapists indicating they hold negative attitudes toward clients who lie, this suggests forensic therapist's may be internalizing the deception rather than looking for the motivation behind the deception. Prior research has shown that in order for forensic therapists and their clients to be successful, the therapist must accept their feelings about their clients past in order to be able to help the client reduce criminal thinking (Varghese, et al., 2015). They must also address and accept their clients present. A forensic client may have several different motivations for telling a lie such as evading responsibility for additional legal charges (Saberi, et al., 2013) or possibly current charges. Rather than internalizing the deception it may prove more beneficial for the therapeutic relationship to explore the motivation for deception.

Forensic therapists also held two more pro-social attitudes toward clients who lie indicating they view clients as less weak and less lazy. These results may be due to the

therapist perceiving the client as actively attempting to manipulate in an effort to push their own agenda. According to the Encyclopedia of Deception (2014), manipulation is more likely to occur when an "individuals' choices are highly limited by the power of others" (p. 643). In order for inmates to be successful at manipulating correctional staff it can require careful calculations on the inmate's part. Inmates will study staff schedules and behaviors carefully (Shively, 2015) in an effort to determine who the most susceptible target is.

Due to criminals operating in a culture that is generally much more deceptive than non-criminals (Vrij & Semin, 1996), it is safe to say that forensic therapists will encounter a client being deceptive at some point. Should a forensic therapist determine they have been duped this may ignite feelings of embarrassment and anger (Curtis, 2013). A frequency analysis was run on the first two items of the BCDQ asking forensic therapists' to compare non-forensic clients to forensic clients. From a no change anchor of 4, forensic therapists indicated they believe more forensic clients lie ($M = 4.83$) than non-forensic clients and forensic clients lie more often ($M = 5.11$) than non-forensic clients. Forensic therapists may believe this due to the environment forensic clients are in, they may be lying in an effort to not be deemed a "snitch", in an effort to avoid taking responsibility for their actions, in an attempt to receive special treatment, or possibly to hide other transgressions.

Forensic therapists were asked a series of questions based off DePaulo's (1996) findings of clients' motivation to lie. DePaulo and colleagues discovered that liars lie about themselves a great deal, utilizing self-oriented lies 50% of the time and other-oriented lies 25% of the time, with the reaming 25% using both self-oriented and other-oriented lies (DePaulo et al., 1996). Forensic therapists indicated they perceive clients lie for themselves

more than they lie for others or for themselves and others. Forensic therapists indicated they perceive clients lie for others less than they lie for themselves and others. According to DePaulo's findings these should be the same however it appears forensic therapists perceive their clients practice self-oriented lies most.

The results of this study add to the literature of deception and the necessity for training and practice in deception detection. Based off the present study, showing forensic therapists hold inaccurate beliefs about deception as well as negative attitudes toward clients who lie, should a forensic therapist mistakenly believe a client is being deceptive this may pose potential problems to the therapeutic relationship. This demonstrates a need for therapists to explore client deception and motivation for deception further. Curtis (2015) recently started testing the effectiveness of an educational workshop aimed at increasing correct beliefs about indicators of deception and reducing negative attitudes towards clients who lie. This workshop has been shown to be efficacious for physical therapy students as well as nursing students and general university students (Curtis et al. 2015).

Limitations

There were some limitations to the current study. The study had a small sample pool of 48 with ten participants not completing the questionnaires. The ten participants were therefore omitted from analysis resulting in only 38 participants. Some participants missed a few questions; missing data was excluded from analysis. Low levels of participation may be contributed to facility requirements of having any study vetted before being able to participate. The current study also had more women participants than men. Of the 38 participants 29 of them were women and only nine were men.

Another limitation is the reliability of the TATDS when measuring forensic therapists' attitudes. A total score was calculated for the TATDS and then a reliability analysis was ran to assess Cronbach's alpha. The total TADTS score for forensic therapists resulted in a lower value ($\alpha = .686$) compared to the reliability of therapists ($\alpha = .832$). This was further broken down into total scores for specific and global attitudes. Global attitude results indicated poor internal consistency ($\alpha = .560$) whereas specific attitude item values indicated an acceptable internal consistency ($\alpha = .772$).

Conclusion

Congruent with prior research, the current study revealed forensic therapists do not hold accurate beliefs about indicators of deception. These inaccuracies could cause a therapist to misinterpret behaviors as an indication of deception when a statement may in fact be the truth. For example, should a forensic therapist hold the belief that eye contact changes when a client is being deceptive, when prior research indicates there is no change in this behavior and is therefore not a good premise to base an assumption of deception on, the therapist may be wrongfully determining a client is lying. These inaccurate beliefs can be detrimental to the therapeutic process due to forensic therapists indicating they hold some negative attitudes toward those who lie.

Future researchers are encouraged to continue exploring deception within a forensic context. Specifically, researchers should look at beliefs and attitudes toward deception of probation officers, correctional officers, lawyers, judges, and anyone else involved with corrections. Another area for researchers to explore would be the attitudes and beliefs of jurors toward deception. Jurors are a collection of individuals from many different

educational backgrounds acting as representatives for their community. These individuals are responsible for determining guilt or innocence for those charged with breaking the law. The implications for jurors holding inaccurate beliefs about deception as well as negative attitudes toward liars can have dire consequences possibly resulting in a wrongful determination of guilt. Overall, this study contributes to the field of forensic therapy and deception literature.

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APPENDICES

APPENDIX A

Demographic Questionnaire

Age:_____

Gender: ___Woman ____Man ____Transgender

Race/Ethnicity:

____ 1) African American/Black

____ 2) Caucasian/European American

____ 3) Asian/Asian American/Pacific Islander

____ 4) Native American/Alaskan Native

____ 5) Hispanic/Latina/Latino

____ 6) Bi Racial

____ 7) Multiracial

____ 8) Other: _____

Education:

____ 4 year college degree

____ Master's degree

____ Ph.D.

Training Program:

____ Clinical

____ Counseling

____ Other: _____

License:

____ Licensed Chemical Dependency Counselor

____ Licensed Chemical Dependency Counselor - Intern

____ Licensed Professional Counselor

____ Licensed Professional Counselor - Intern

____ Licensed Psychological Associate

____ Licensed Psychologist

____ Other: _____

Current Therapy Work Setting:

____ Men's Community Correctional Facility (CRTC)

____ Men's Community Correctional Facility (SAFPF)

____ Women's Community Correctional Facility (CRTC)

____ Women's Community Correctional Facility (SAFPF)

____ Other: _____

Training:

How much literature have you read on deception (books or articles)?

1	2	3	4	5	6	7
None						Very Much

How much training have you had with deception?

1	2	3	4	5	6	7
None						Very Much

How much training have you had with deception detection?

1	2	3	4	5	6	7
None						Very Much

How many years of counseling experience? _____

How many direct contact hours? _____

APPENDIX B

Detection of Deception Questionnaire

For the following questions, *circle* the number that most closely corresponds with your opinions.

1. **How confident are you that you can detect when clients are deceptive to you?**

1	2	3	4	5	6	7
Not Very Confident						Extremely Confident

2. **How often do you think clients would be deceptive to you?**

1	2	3	4	5	6	7
Very Rarely						Very Often

Please indicate whether the following behaviors increase or decrease when clients lie to you.

3. **Eye contact**:

1	2	3	4	5	6	7
Decreases a lot			Does Not change			Increases a lot

4. Eye blinks:

1	2	3	4	5	6	7
Decreases a lot			Does Not change			Increases a lot

5. Head movements:

1	2	3	4	5	6	7
Decreases a lot			Does Not change			Increases a lot

6. Smiles:

1	2	3	4	5	6	7
Decreases a lot			Does Not change			Increases a lot

7. Hand and finger movements:

1	2	3	4	5	6	7
Decreases a lot			Does Not change			Increases a lot

8. Arm movements:

1	2	3	4	5	6	7
Decreases a lot			Does Not change			Increases a lot

9. Leg and foot movements:

1	2	3	4	5	6	7
Decreases a lot			Does Not change			Increases a lot

10. Postural shifts:

1	2	3	4	5	6	7
Decreases a lot			Does Not change			Increases a lot

11. Shrugs:

1	2	3	4	5	6	7
Decreases a lot			Does Not change			Increases a lot

12. Gestures:

1	2	3	4	5	6	7
Decreases a lot			Does Not change			Increases a lot

13. The number of speech interruptions such as “uh” and “um”:

1	2	3	4	5	6	7
Decreases a lot			Does Not change			Increases a lot

14. The number of pauses or hesitations in speech:

1	2	3	4	5	6	7
Decreases a lot			Does Not change			Increases a lot

15. The amount of time before beginning to respond to a question:

1	2	3	4	5	6	7
Decreases a lot			Does Not change			Increases a lot

16. Hectic speech patterns:

1	2	3	4	5	6	7
Decreases a lot			Does Not change			Increases a lot

17. Changes in the pitch of voice:

1	2	3	4	5	6	7
Decreases a lot			Does Not change			Increases a lot

18. The length of answers:

1	2	3	4	5	6	7
Decreases a lot			Does Not change			Increases a lot

19. The use of short, simple sentences in stories and explanations:

1	2	3	4	5	6	7
Decreases a lot			Does Not change			Increases a lot

20. The use of plausible descriptions in stories and explanations:

1	2	3	4	5	6	7
Decreases a lot			Does Not change			Increases a lot

21. Logically consistent stories and explanations:

1	2	3	4	5	6	7
Decreases a lot			Does Not change			Increases a lot

22. The amount of detailed descriptions in stories and explanations:

1	2	3	4	5	6	7
Decreases a lot			Does Not change			Increases a lot

23. Unusual details in descriptions:

1	2	3	4	5	6	7
Decreases a lot			Does Not change			Increases a lot

24. Unnecessary details in descriptions:

1	2	3	4	5	6	7
Decreases a lot			Does Not change			Increases a lot

25. Descriptions of their own feelings or the feeling of others:

1	2	3	4	5	6	7
Decreases a lot			Does Not change			Increases a lot

26. Recounting exactly what somebody had said in stories and explanations:

1	2	3	4	5	6	7
Decreases a lot			Does Not change			Increases a lot

27. Descriptions of interactions with others in stories and explanations:

1	2	3	4	5	6	7
Decreases a lot			Does Not change			Increases a lot

28. Spontaneous corrections in stories and explanations:

1	2	3	4	5	6	7
Decreases a lot			Does Not change			Increases a lot

29. Claiming a lack of memory for certain events or information:

1	2	3	4	5	6	7
Decreases a lot			Does Not change			Increases a lot

30. Stories with contradictions:

1	2	3	4	5	6	7
Decreases a lot			Does Not change			Increases a lot

APPENDIX C

Therapist Attitudes Toward Deception Scale

If you discovered that a client was lying to you, how would that affect:

1. Liking the client?

1	2	3	4	5	6	7	8	9
Significantly Decreases				No Change				Significantly Increases

2. Being angry at the client?

1	2	3	4	5	6	7	8	9
Significantly Decreases				No Change				Significantly Increases

3. Seeing the client as a bad client?

1	2	3	4	5	6	7	8	9
Significantly Decreases				No Change				Significantly Increases

4. Thinking negatively about the client?

1	2	3	4	5	6	7	8	9
Significantly Decreases				No Change				Significantly Increases

5. Judging the client harshly?

1	2	3	4	5	6	7	8	9
Significantly Decreases				No Change				Significantly Increases

6. Desire to interact with the client?

1	2	3	4	5	6	7	8	9
Significantly Decreases				No Change				Significantly Increases

7. Enthusiasm to interact with the client?

1	2	3	4	5	6	7	8	9
Significantly Decreases				No Change				Significantly Increases

8. Judging the client as a good client?

1	2	3	4	5	6	7	8	9
Significantly Decreases				No Change				Significantly Increases

9. Speaking poorly of the client with others?

1	2	3	4	5	6	7	8	9
Significantly Decreases				No Change				Significantly Increases

10. Trusting the client?

1	2	3	4	5	6	7	8	9
Significantly Decreases				No Change				Significantly Increases

11. Thinking positively about the client?

1	2	3	4	5	6	7	8	9
Significantly Decreases				No Change				Significantly Increases

12. Viewing the client as sincere?

1	2	3	4	5	6	7	8	9
Significantly Decreases				No Change				Significantly Increases

13-24. Clients who lie in therapy compared to clients who do not lie in therapy are:

1	2	3	4	5	6	7
Not Very Successful						Very Successful

1	2	3	4	5	6	7
Not Very Pathological						Very Pathological

1	2	3	4	5	6	7
Not Very Weak						Very Weak

1	2	3	4	5	6	7
Not Very Compliant						Very Compliant

1	2	3	4	5	6	7
Not Very Predictable						Very Predictable

1	2	3	4	5	6	7
Not Very Pleasant						Very Pleasant

1	2	3	4	5	6	7
Not Very Lazy						Very Lazy

1	2	3	4	5	6	7
Not Very Awkward						Very Awkward

1	2	3	4	5	6	7
Not Very Knowledgeable						Very Knowledgeable

1	2	3	4	5	6	7
Not Very Intelligent						Very Intelligent

1	2	3	4	5	6	7
Not Very Likable						Very Likable

1	2	3	4	5	6	7
Not Very Adjusted						Very Adjusted

25. What percentage of clients on your caseload are liars? _____

APPENDIX D

Beliefs about Client Deception Questionnaire

1. Compared to a non-forensic client, how many forensic clients lie?

1	2	3	4	5	6	7
Significantly Less			No Change			Significantly More

2. Compared to a non-forensic client, how often do forensic clients lie?

1	2	3	4	5	6	7
Significantly Less			No Change			Significantly More

3. When clients lie how often do you rely on verbal indicators to detect deception?

1	2	3	4	5	6	7
Less Often			No Change			More Often

4. When clients lie how often do you rely on paraverbal indicators to detect deception?

1	2	3	4	5	6	7
Less Often			No Change			More Often

5. When clients lie how often do you rely on nonverbal indicators to detect deception?

1	2	3	4	5	6	7
Less Often			No Change			More Often

6. How often do clients lie for themselves?

1	2	3	4	5
Never				Always

7. How often do clients lie for others?

1	2	3	4	5
Never				Always

8. How often do clients lie for themselves and for others?

1	2	3	4	5
Never				Always

APPENDIX E

Email Request

Good Morning,

I am a student at Angelo State University currently working on my thesis, under the supervision of Dr. Drew Curtis. Please consider participating in an online study consisting of participants completing questionnaires regarding attitudes and beliefs toward deception within a forensic context. This study is available for therapists who work with clientele who are part of the criminal justice system, whether that be clients currently incarcerated, at an alternative correctional facility, or court mandated to see a therapist.

If you would be willing to pass this email on to other therapists fitting the above criteria or be willing to provide me with any resources (a listserv or professional contacts) that would be greatly appreciated.

https://www.psychdata.com/s.asp?SID=175325

Thank you for your time,

Chelsea Dickens

Chelsea Dickens
Teaching Assistant
Department of Psychology, Sociology, and Social Work
Angelo State University
Member, Texas Tech University System

ANGELO STATE UNIVERSITY
College of Graduate Studies
Institutional Review Board

12/14/2016

Dr. Drew Curtis
Dept. of Psychology, Sociology, & Social Work
Angelo State University
San Angelo, TX 76909

Dear Drew:

The proposal submitted by your student Chelsea Dickens titled, "*Deception in Therapy: Forensic Therapists' Beliefs and Attitudes*" was reviewed by Angelo State University's Institutional Review Board for the Protection of Human Research Subjects in accordance with federal regulations 45 CFR 46; your protocol has been APPROVED.

The protocol has been approved for one year effective December 14, 2016, and expires one year from this date. If your project will continue beyond one year, please be aware that you must submit a request for continuation before the current protocol expires.

The IRB protocol number for your approved project is #CUR-121416. Please include this number in the subject line of all future communications with the IRB regarding the protocol.

Sincerely,

Teresa (Tay) Hack, Ph.D.
Chair, Institutional Review Board

ANGELO STATE UNIVERSITY
College of Graduate Studies
Institutional Review Board

02/17/2017

Dr. Drew Curtis
Dept. of Psychology, Sociology, & Social Work
Angelo State University
San Angelo, TX 76909

Dear Drew:

The proposed addendum submitted by your student, Ms. Chelsea Dickens, for her project that was previously approved by the IRB on December 14, 2016, titled, "*Deception in Therapy: Forensic Therapists' Beliefs and Attitudes*" has been reviewed and APPROVED in accordance with federal regulations 45 CFR 46.

The approved addendum is effective beginning February 17, 2017. Please be aware that the protocol will expire one year from its original approval date, which will be December 14, 2017. If the study will continue beyond that date, you must submit a request for continuation before the current protocol expires.

The approved addendum is for protocol #CUR-121416. Please include this number in the subject line of in all future communications with the IRB regarding the protocol.

Sincerely,

Teresa Hack, Ph.D.
Chair, Institutional Review Board